PA#		
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## Medicaid Ambulance Review Prior Authorization

Date:	Caller Name:		]	Phone:				
Time:	Dept							
		Client 1	Information					
Participant Na	me:	Date of Birth:						
Medicaid ID N	umber							
Eligibility Veri	fied? Yes / No Med	licare or Other	Insurance: Yes / I	No Type:				
		Provide	· Information					
Ambulance <b>F</b>	Provider:	Contact:						
		Transpor	t Information					
Transfer Dat	te:Time:	Time: LOS Required: BLS / ALS / Spec/Neo						
Pick up Poin	t:	Destination:						
Dis Physiciar	ı:	]	Rec. Physician:					
Admit Date:								
Dx:								
Medical Reas	son for TX:							
	R:B/P:							
Notes:								
Previous HX:								
rrevious ma:								